South Coast Hearing Specialists

Patient Information

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: *Street:* _____

City: _____ *State*: _____ *Zip:* _____

Home Telephone: _____ Cellphone: _____

Work Phone: _____ Email: _____

Preferred method of communication? Please check one: ☐ *Home* ☐ *Cell* ☐ *Work* ☐ *Email* ☐ *Text*
Would you like to receive billing statements via email?: ☐ *Yes* ☐ *No*

Social Security Number: _____ Driver's License Number: _____

Employer: _____

Emergency Contact: _____

Relation: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referred by: ☐ Doctor: _____ Phone: _____
☐ Internet: _____ ☐ Senior Center
☐ Family/Friend: _____ ☐ Insurance
☐ Other: _____ ☐ Letter or Mailer

Insurance Information (Please provide your insurance card(s) to copy)

Primary Insurance: _____

Name of Responsible Party/Subscriber: _____ Date of Birth: _____

Secondary Insurance: _____

Name of Responsible Party/Subscriber: _____ Date of Birth: _____

I hereby certify that the above information is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Dr. RoseMarie Davis and her staff, whether covered by insurance or not.

_____

Patient's or Patient Representative's Name and Signature Date